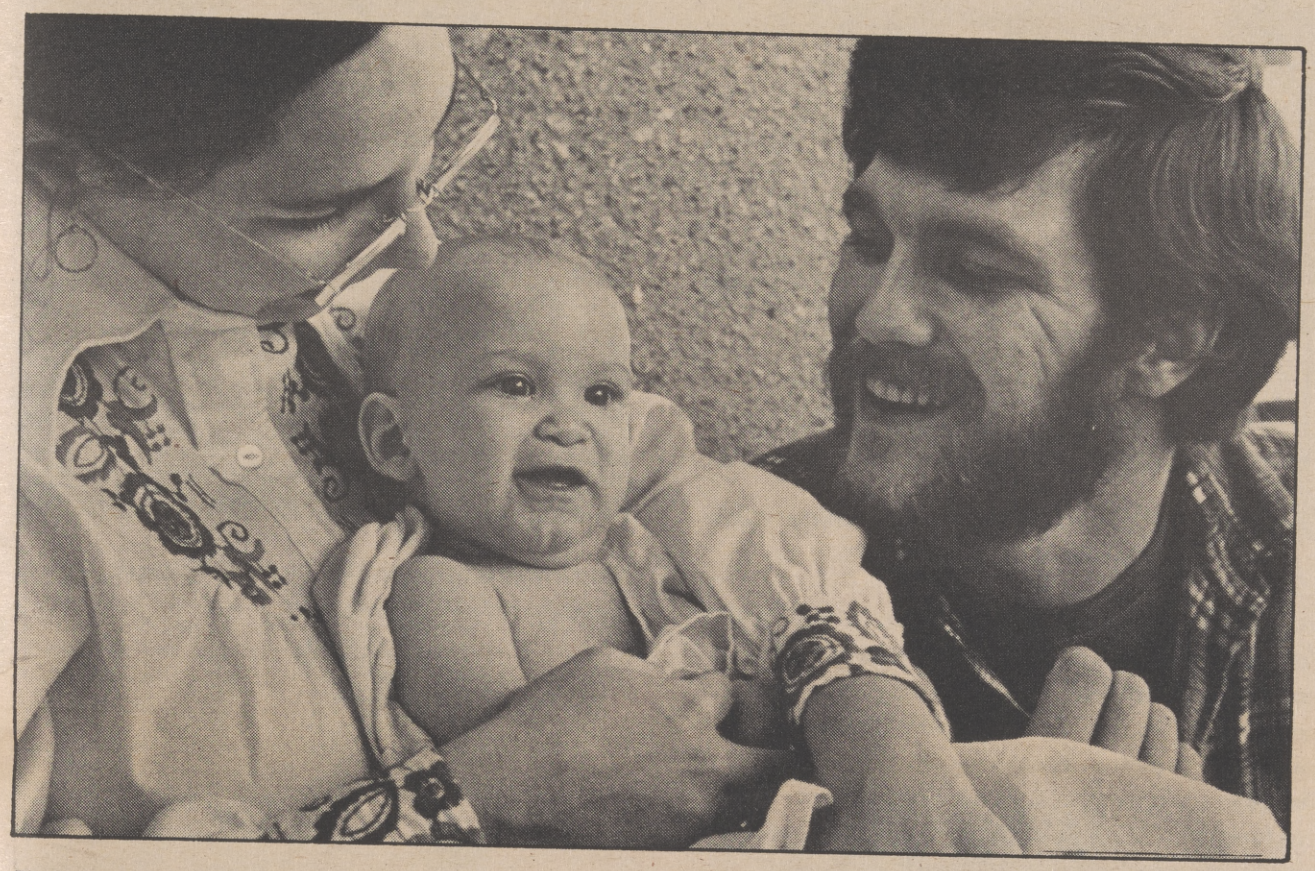
UCSF NEWS

The Breath of Life



Kathy and Gregg Underwood of Auburn, California, are proud of their son, Matthew, age 4 months. Matthew Jason Underwood was flown to UCSF within 3 hours after his birth to receive treatment in Moffitt Hospital's Intensive Care Nursery.

Within three hours after his birth last August 12th, Matthew Jason Underwood had travelled 150 miles by helicopter and ambulance. It was a journey that saved his life.

At midnight on that August day, Dr. Dwight Odom delivered Matthew in the small Mother Lode town of Auburn, California. He recognized immediately that the infant was suffering from a severe breathing problem. (Respiratory Distress Syndrome or Hyaline Membrane Disease are the technical names used for the type of breathing problem which afflicted him.) Dr. Odom knew that the infant's chance for survival depended upon getting to a unit specially equipped to care for newborn babies who are critically ill. The unit in Sacramento was filled and it was recommended that he be taken to The University of California's Moffitt Hospital in San Francisco.

A system in which the U.S. Air Force coordinates emergency flights was alerted. Dr. John Carey and nurse Marti Heller from UCSF, specialists in the care of newborn infants suffering from Respiratory Distress Syndrome (RDS), were flown in an army helicopter to Auburn. After leaving them at the hospital parking lot, the 'copter headed for Sacramento to refuel and developed trouble which made a forced landing at Penryn, California, necessary. The Coast Guard was called to send another helicopter to pick up the doctor-nurse team and the Underwood baby. Little Matthew's treatment was started at Auburn Faith Hospital and was continued during the flight and ambulance trip from Cressy Field to Moffitt Hospital.

Through a closely integrated program involving patient care and research, UCSF has an impressive record of achievement in the Intensive Care Nursery. During the past several years, the number of deaths, there, from RDS had been cut in half. Equally important is the evidence that the children who survive develop into normal, healthy children.

This disease, which takes such a toll on premature infants, is one in which the lungs do not function properly because they are not mature. A substance called surfactant is not produced and microscopic air sacs within the lung tissue collapse. Matthew Underwood was one of the thousands of babies born each year in this country who are victims of this condition.

During the first few days of his life when little Matthew was considered to be in critical condition, he was treated with a technique developed at UCSF called Continuous Positive Airway Pressure (CPAP). Through a tube placed in his mouth and throat, a mixture of oxygen and air, kept at a carefully gauged pressure, flowed into his lungs. This pressure was maintained at a constant level to keep his lungs from collapsing. When his lungs began to manufacture surfactant, the pressure was gradually decreased until he was able to breathe independently.

Research Led to Treatment

It was from basic studies at UCSF that diagnostic techniques and treatment, now used throughout the country, were developed for infants with RDS. The research work was done in the Cardiovascular Research Institute (CVRI) at the UCSF Medical Center. The physicians who worked on the studies hold dual appointments in the CVRI and in the School of Medicine's Department of Pediatrics.

Research in the CVRI is concerned with all aspects of heart and lung function and with blood circulation. Before progress can be made in treatment or cure of diseases, it is necessary to understand the mechanisms that cause the disease. It is research, working closely with clinical situations, that eventually supplies the answers.

A Cooperative Effort

More than ten years ago, studies by John A. Clements, M.D., Professor of Pediatrics and a Career Investigator in the CVRI and William H. Tooley, M.D., Professor of Pediatrics and also a member of the CVRI, had defined the causes and problems associated with RDS (hyaline membrane disease). The use of CPAP was successfully developed in 1969 by Dr. George A. Gregory, M.D., Associate Professor of Pediatrics and Anesthesiology, who collaborated with Drs. Joseph A. Kitterman, Roderic Phibbs, and

William Tooley . . . all pediatricians and members of the CVRI. Drs. Phibbs and Kitterman also specialize in neonatology, a relatively new specialty concerned with the health of a fetus during pregnancy.

Progress made in understanding the disease, RDS, and in applying treatment has been the direct result of the activities of these UCSF faculty members, as well as of the preliminary observations and predictions made several years before their work by Dr. William K. Hamilton, now Chairman of the Department of Anesthesiology. Dr. Gregory's approach to treatment stemmed from his training in anesthesiology, in which patterns of breathing are closely observed and understood.

Breathing is assumed by most of us to be purely a reflex action . . . something we don't think about unless there is intereference. To scientists and physicians who are concerned with lung function, however, breathing is a complex process. One mechanism still not understood, for example, is the one that initiates the first breath of air a newborn infant takes.

Intensive Care Nursery

The Intensive Care Nursery program at UCSF was started in 1961. At that time Dr. William Tooley and his colleagues began to consolidate the treatment area for sick infants and to use a different system of classifying infants. The traditional separation of babies by weight . . . a system that labeled infants under 2,500 grams (5 lbs.) at birth as premature . . . was abandoned. It was decided that infants would be placed in the Intensive Care Nursery on the basis of whether they were considered to be "sick" or "well," regardless of weight. Babies born at other hospitals in the Bay Area were also admitted to the Nursery. Nurses were given additional training in the care of these infants and in the use of highly technical monitoring apparatus.

Special Nursing Care

Dr. Joseph A. Kitterman, who worked with Dr. Gregory to perfect the life-saving technique for RDS babies, considers the nursing service in the Intensive Care Nursery, a major factor in the success of UCSF's program to care for severely sick infants.

Matthew Jason Underwood, as do all critically ill infants in the Intensive Care Nursery, had a nurse beside his crib twenty-four hours a day. These were nurses with additional training to manage very sick infants who need care that involves special skills and a knowledge of newborn physiology. A complex electronic monitoring system continually charts heart rate, breathing rate, and chemical analysis for each infant. Nurses in the Intensive Care Nursery, must not only keep the infant under constant observation but must interpret the monitor's panel of lights and the charts that roll continuously from the recording machine.

The "Foam Test"

Within the past two or three years, other techniques and tests developed by the UCSF physician-researcher team have improved health care services for newborn infants. Obstetricians and pediatricians believe that the best time to start thinking about a baby's health is during pregnancy.

"Good prenatal care is a factor we cannot stress enough," said Dr. Roderic H. Phibbs, currently Director of the Intensive Care Nursery. "Treatment of a sick infant can be started before birth and, with knowledge that an unborn infant is in distress, we can be fully prepared to manage any emergency at the time of delivery."



Dr. Roderic Phibbs (right) attending Matthew Underwood in the Intensive Care Nursery.

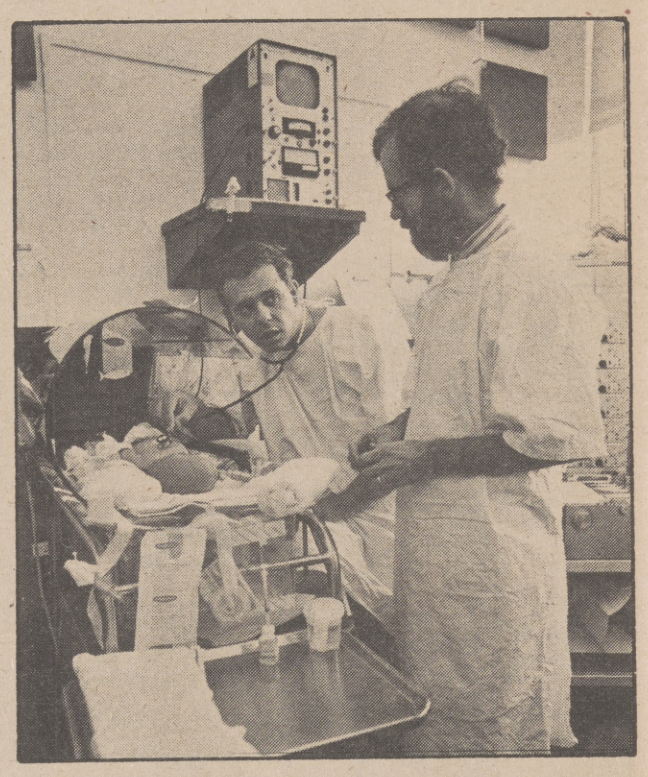
One of the prenatal tests developed by the UCSF team, in cooperation with another team at UCLA, is called the "foam test." By withdrawing a small amount of amniotic fluid in which the baby is surrounded while in the uterus, technicians are able to learn whether the unborn infant's lungs are mature enough to function. This is done by analyzing the fluid to determine whether or not the substance called surfactant is present and in what amounts. This "foam test" was a product of research in which obstetricians, pediatricians, physiologists, and laboratory technicians collaborated. As one researcher observed: "With expertise from many sources, we were able to quickly apply the results of basic scientific research to a clinical problem. A medical center, such as UCSF, is the ideal setting for this kind of progress in health care."

Teaching By Demonstration

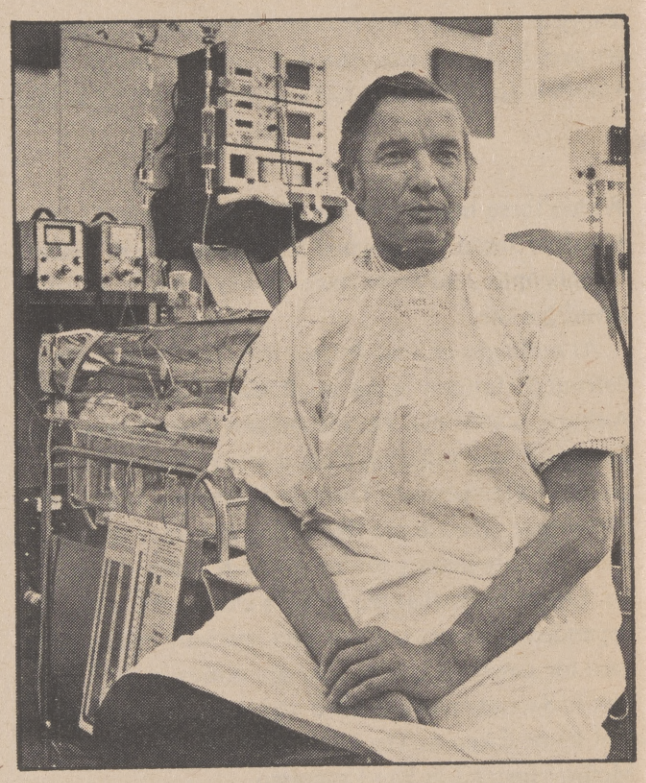
Extending knowledge and skills to other hospitals and physicians is an inevitable by-product of the Intensive Care Nursery program. For infants who are not born at UCSF, instructions are given to those who must care for the sick baby before the UCSF team arrives. Treatment begins immediately and those in other hospital nurseries participate. The youngster's physician is kept posted on the small patient's progress and as soon as the critical period is past, the infant is returned to the care of the referring physician and hospital. If some aspect of care can be continued at the referring hospital, a member of the UCSF Nursery accompanies the baby when it is taken to the other nursery and demonstrates or consults if necessary. Consultation for physicians and other nursery staff members is never more than a telephone call away.

Facts prove the success of the Intensive Care Nursery Program at UCSF. *Figures* show the drop in mortality rate and the *children* who return at regular intervals to the clinic show the quality of the life that was saved.

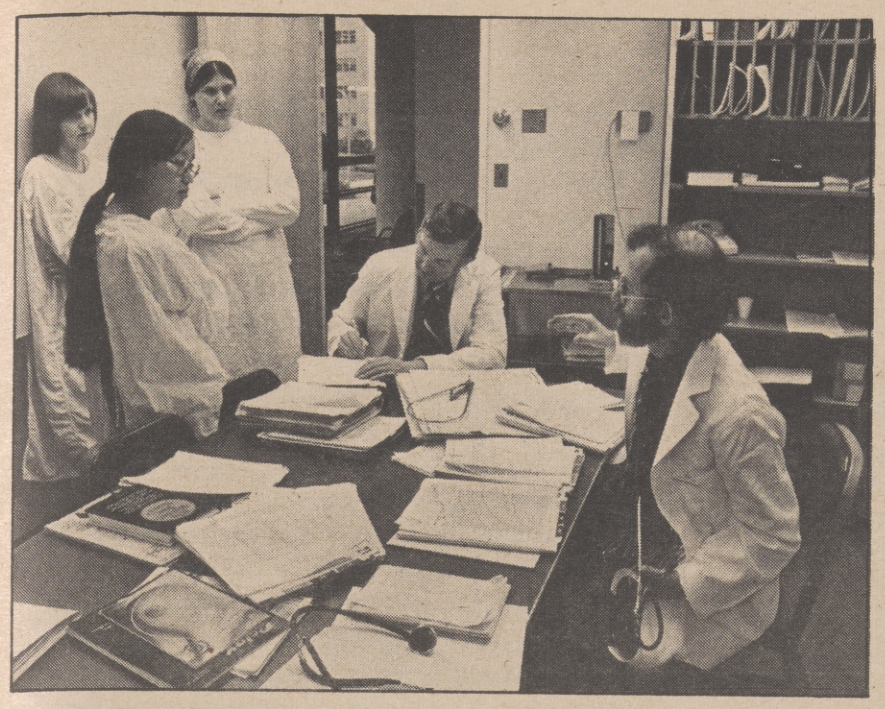
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Dr. George A. Gregory (left) and Dr. Joseph A. Kitterman check a young patient with RDS.



William H. Tooley, M.D., Professor of Pediatrics and a pioneer in research and treatment of the Respiratory Distress Syndrome.



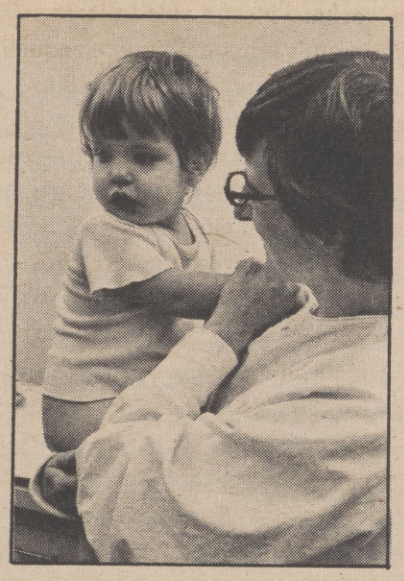
The atmosphere of the follow-up clinic for babies who were treated in the Intensive Care Nursery is more like a family reunion than a clinic. Each infant in the Nursery receives not only expert medical care but the personal attention and warmth of those who remain with them around the clock. Physicians and nurses stroll through the clinic visiting with the youngsters.



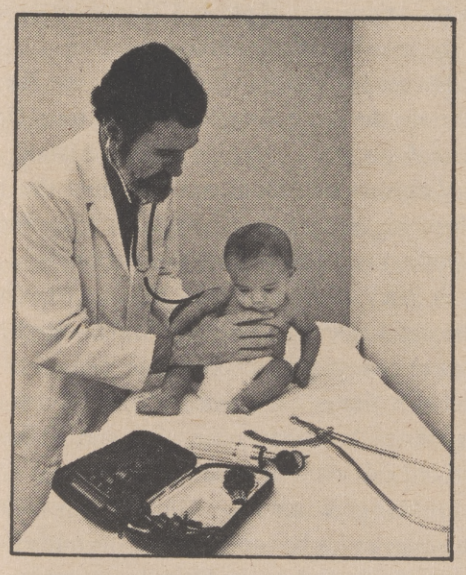
Shirley Grimes maintains the follow-up records on Intensive Care Nursery patients and schedules their periodic clinic visits. The new clinic facilities include a large blackboard in the conference room. Each child's examination and tests are noted and checked on the board, as well as the name of the attending physician.



Dr. Joseph A. Kitterman holds Jerome Ungson at the follow-up clinic. Jerome weighed about 2 lbs. at birth, and underwent heart surgery when one week old.



Mary Catherine O'Dell was flown to UCSF shortly after her birth. A victim of respiratory distress, Mary Catherine was born in Sonora, then transferred by ambulance to Modesto where an army helicopter with a physician-nurse team from UCSF's Intensive Care Nursery met her and flew the trio to San Francisco.



Juan Miguel Ramirez, born 3 weeks prematurely in Redding, California, is checked by Dr. Roderic Phibbs, Director of the Intensive Care Nursery.



The Intensive Care Nursery, showing cribs and monitoring systems for severely ill infants.

Photographs taken by Tom Walters.

The Feast of Lights

Ancient man took fearful note of the shortening days of winter when the sun seemed to be dying and all plant life, except the evergreens, shrivelled and died. At winter solstice when the days began to lengthen, he celebrated with wild joy—the sun had died and was now reborn.

From the dimmest reaches of time up to the present, mankind has always held celebrations around the winter solstice (December 22). The rituals and relics derived from those ancient pagan observances can still be found in the modern feast days of the Judeo-Christian world.

German and Celtic tribes held the festival of Yule to commemorate the return of the burning wheel—the sun. A huge log was chosen, blessed with much ceremony, then lit. Each year a branch from the log was saved to rekindle a new fire. Because this Yule period comes at the same time as Christmas, the word is used in most northern countries for the Christmas season.

Also deriving from these times are the use of evergreens for Christmas decorations, the wassail bowl, and candles, and lights. The sun, moon, and stars have always stood as symbols of the Divine and, in olden times torches, watch fires, beacon lights and lamps were used to celebrate festivals.

The theme of the birth of a god in the dying year prevailed in many pagan religions, prefiguring the birth of Jesus. In Persia, Mithras, the god of light, defender of truth, and enemy of the powers of darkness, was worshipped at the winter solstice. Mithraism became a popular cult, spread throughout Rome and Greece by Roman soldiers.

The early Egyptians also celebrated this midwinter festival, claiming that Horus, the god of day, was born to Isis, goddess of motherhood and fertility, at the close of December.

To the Jews, the midwinter period was the Festival of Lights, or Dedication, called Hanukkah or Chanukah. Twenty-one centuries ago, a little band of Jewish soldiers led by Judas Maccabeus fought and won the first recorded battle for religious freedom. They resisted and overcame the mighty Syrian hordes, who, if victorious, would have wiped out Judaism both as a faith and as a nation.

Today this victory is celebrated with the eight-day Feast of Lights. For eight days, beginning on the 25th day of the Hebrew month of Kislev, about the same time as Christmas, Jews give thanks for the great event which meant the survival of Judaism. On each of the eight days they light candles, one the first day, two the second, and so on. A special nine-branch candelabrum, the Menorah, is used, the ninth place providing the extra candle from which the others are lighted. The ninth candle must burn until the last day of Hanukkah, to celebrate the miracle that occurred in the temple when the holy place was redecorated by the Maccabean warriors who had recaptured it from the Syrians. When the lights in the temple were rekindled, the oil that should have burned only one day lasted for an entire week.

The customs of Hanukkah are not unlike the customs of Christmas. Among the traditional Hanukkah decorations is the six-pointed Star of David. Gifts exchanged by family and friends are wrapped in paper colored blue and white—the colors of the Jewish flag. A special symbol of the festival is the elephant, because of the trained elephants used by the Syrian armies, and the hammer, in commemoration of Judas Maccabeus, who was called "Judas the Hammerer."

Just as the Christians place candles in the window to guide the Christ child through the darkness to the house, so is the Menorah placed by Jews near a window so that all may see it glow as a symbol for light, truth, and liberty.

Christmas as we know it today, with all the rites and observations to commemorate the birth of Christ, also had its origins so long ago we rarely think of their derivation from pagan practices. Yet even the date of December 25 was not settled upon until the fifth century. Christmas, which derived from the medieval *Christus Masse* feast of medieval times, was not celebrated in the first centuries of the Christian Church because Christian usage then was to celebrate the death rather than the birth of a remarkable person. Moreover, the exact date of Christ's birth has never been discovered.

The early Church fathers wisely transformed pagan festivals into practices having a Christian significance rather than trying to abolish them, so as to purify and preserve for the new faith whatever was innocent and deeply loved in the old. In the yet unconverted world of the fourth century, December 25 was already a sacred day for thousands of people throughout the Roman Empire—the feast of Sol, or birthday of the unconquered sun. This date fell between the week-long feast of the Saturnalia, which began on December 17, and coincided closely with all those midwinter festivals which the primitive peoples of Europe and Asia had celebrated since time immemorial. Thus the Church, by making December 25 also the Feast of the Nativity, sanctified and renewed this date.

Our ancestors decorated their houses with evergreens at the Winter Solstice, and lit bonfires in high places to strengthen the reviving sun in its course. During the Saturnalia, candles and green wreaths were given as presents, and the streets were crowded with noisy processions of garlanded men and women carrying lighted tapers. The early Church forbade the custom of decorating homes with evergreens as savoring of paganism, but the custom was too deeply rooted for such prohibitions to have permanent effect.

Holly, ivy, and mistletoe are still favorite decorations today—symbols of enduring life and fruit-bearing. Mistletoe, the Golden Bough of classical legend, was held sacred by the Celtic Druids and the Norsemen and said to bring good luck and fertility.

The Yule tree, rarely seen now, was still well known in the last half of the last century. It was very large, as it had to burn throughout Christmas Day and throughout the whole Twelve Days—referred to so often in old English carols.

It was the pagan origin of these and other customs which so offended the Puritans in the sixteenth and seventeenth century and gave strength to their attacks upon Christmas itself. During the Commonwealth, when the Puritan party was in power, all celebrations, both religious and secular, were forbidden. Churches were closed: December 25 was proclaimed an ordinary working day, and those who persisted in treating it as a holy day were fined or imprisoned. With the Restoration, Christmas came into its own again, though some ancient customs had lost a little of their vigor.

In the Puritan colonies in New England, Christmas celebrations were forbidden by the authorities in 1659, and this law was not repealed until 1681. Elsewhere in the New World, however, immigrants of other faiths had brought their own customs with them and so kept the festival in their new homes as they had done in their old. With the decline of religious and political bitterness, one after another of the states of the Union acknowledged the importance of Christmas Day by making it a legal holiday, beginning with Alabama in 1836. Today few Americans know that Christmas was ever outlawed in their country, and now Christmas is for them as deeply loved a festival as it is in any other part of Christendom.

Santa Claus, as he is known in America and England, originated from Saint Nicholas, who was a real person—the Bishop of Myra, in Asia Minor in the fourth century. Saint Nicholas became the patron saint of children and sailors. He was especially loved by the Russian peasant because he protected the weak and poor against the strong and rich. And, according to legend, people in the seaport city of Venice adopted him as their patron after he had quieted a terrible storm at sea while on a voyage to the Holy Land.

In some countries of Europe he does not come on Christmas Eve but arrives on his own eve, which is the night before December 6. Also, he does not come down the chimney after the household is asleep but instead knocks on the door and is admitted by the family, who have just finished eating supper. Although he is jovial, like Santa Claus, the big bag on his back carries cookies and fruits, not gifts. He questions the youngsters about their behavior in the past year and their future intentions and, if pleased, dispenses sweetmeats and the promise of something more on Christmas. However, it is the Christ Child, not the saint, who brings the promised gifts on Christmas Day.

St. Nick took on many German characteristics during the Victorian era, for it was then that the custom of bringing trees indoors and decorating them became popular, first in Germany, then in England. Eventually St. Nick, or Santa Claus, became what he is today, the night rider in a reindeer-drawn sleigh, descender of chimneys and the supreme bringer of gifts for children almost everywhere. With all the transformations he has undergone, however, he has always been old and white-bearded, and this is as it should be, for his age is immense. Once he was Odin, the ancient Norse god, who rode through the midwinter mists on his eight-footed horse Sleipnir, bringing wonder and awe, reward or punishment.

Joan Spiegelhalter

War On Gum Disease

The World Health Organization has stated that diseased gums are among man's commonest afflictions, surpassing even the common cold. Ninety percent of adult Americans suffer from gum disease, which is the primary cause of tooth loss after age 35.

In 1967, the U.S. Public Health Service awarded a seven-year grant for $537,000 to Continuing Dental Education at UCSF to help combat gum disease (periodontitis)—a major health problem. Now in its concluding year, the grant's project director, Dr. Robert W. Parr, talked about what the grant had accomplished.

"The grant enabled us to develop teaching materials which have been highly effective in teaching plaque control, not only to our dental and dental hygienist students but to practicing dentists all over the country, as well," said Dr. Parr, Assistant Clinical Professor and Vice Chairman of Periodontology, UCSF School of Dentistry.

About ten years ago, aside from dentists, few people had ever heard about plaque. Yet researchers had narrowed down the cause of both tooth decay and gum disease to one culprit—bacterial plaque. Only specialists in gum disease (periodontologists) talked much about it to their patients—people who were already suffering with gum disease and loss of teeth. Yet gum disease is preventable.

What is Plaque?

Plaque is a sticky, transparent film that adheres to the teeth. It is composed of saliva, food remnants, and bacteria. This film clings between the teeth and at the gum line—the very areas that toothbrushing alone has difficulty in reaching. Therefore, proper use of dental floss is required for a thorough job. If plaque is not removed within 24 hours, the bacteria form into colonies that produce chemicals which begin to attack the teeth and to irritate the gums. If gum inflammation continues unchecked, gum disease may destroy not only the gum tissues supporting the teeth but also the bone which holds the teeth in their sockets.

What To Do About Plaque

First, see your dentist. He will show you how to identify plaque and instruct you how to remove the film without harming your gums. This thorough removal of plaque should be done at least once a day (it takes 24 hours for bacteria to colonize and start producing harmful chemicals). Plaque is transparent, but there are "disclosing tablets" or solutions now available, which, when chewed or swished in the mouth for 30 seconds, will color the plaque. Now the 'bad spots' can be seen and attacked. The color, a harmless food coloring, disappears within an hour.

Dr. Parr stated that the main problem was to educate the public about plaque and to motivate them in taking an active part to help themselves preserve their own teeth. "To reach the public, we knew we would have to engage dentists in teaching their patients plaque control," said Dr. Parr. "Only through this kind of education could inroads be made upon this preventable disease, for there were not nearly enough specialists in the field to fill the treatment needs of the public or the teaching needs of existing dental schools."

The educational courses, developed by the Section on Instructional System Design in the Division of Periodontology, constituted "a direct attack against gum disease," said Dr. Parr. They were designed primarily as self-instruction courses in the latest methods of prevention and treatment of gum diseases for the use of practicing dentists, many of whom have not had the opportunity for training in specialized treatment of gum disorders.

Among the educational materials is a book called "Developing A Plaque Control Program," which was awarded a prize by the American Dental Association. "The book conveys the necessity for dentists to be good communicators and teachers," said Dr. Parr. "Preventive dentistry is emphasized. Dentists can appeal to their patients' desire to have a healthy mouth, good looks, elimination of bad breath, etc. They can alleviate their anxiety about losing their teeth by motivating them to carry out plaque control techniques and demonstrating to them how they can play a major role in preserving their own teeth."

While discussing sugar, Dr. Parr pointed out that it is not true that in primitive societies where refined sugar is not used there are no dental problems. "They do not have caries (decay) but they can and do have gum problems and can lose their teeth as a result," said Dr. Parr. "No mouth is immune to bacterial plaque."

An indication of how much more knowledgeable the general public is about plaque today than seven years ago is that the subject of bacterial plaque figured in a recent TV comedy situation on The Bob Newhart Show.

Today, UCSF dental school graduates are teaching plaque control in their own practices. Current dental students are doing the same: a large part of their training now takes place in community and outreach clinics, both on a regular and a volunteer basis, where, under faculty supervision, they give dental care *and* teach preventive care. "Although much remains to be done, the UCSF School of Dentistry has done much to help win the war against gum disease," Dr. Parr concluded.

Joan Spiegelhalter

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Household Poisons

"At least 1500 children die each year of accidental poisonings," says Dr. Frederick H. Meyers, Professor of Pharmacology at UCSF. "Two-thirds of these children are under the age of five. And what is so terrible is that most of these deaths could be prevented by the simple expedient of keeping medications and household poisons out of reach or locked up."

Few parents realize that the cupboard under the kitchen sink is chock-full of toxic chemicals capable of killing and maiming their children. These poisons are easily accessible to the crawling baby or to inquisitive toddlers, who will put anything and everything into their mouths, regardless of bad taste or bad odor. "Parents should search the home for dangerous chemicals *before* a child is old enough to creep," says Dr. Meyers.

For instance, furniture polishes frequently contain petroleum distillates that can damage the lungs. A popular drain cleaner contains lye which, if swallowed, can damage the esophagus. Spray-on oven cleaners contain potassium hydroxide, which can burn as severely as lye. Cleansing and scouring powders also contain toxic chemicals, as do household ammonia, detergents, and bleaches. The fumes and gases released by some cleaning agents can do irreparable damage to internal membranes and organs. Spray cleaners often contain ingredients that are caustic to the skin and internal membranes.

"Ninety to 98 percent of poisonings in children can be prevented if parents will take simple precautions and remember the small child's propensity to put everything into his mouth," Dr. Meyers points out. For example, iron tablets and aspirins are often kept in a kitchen cabinet or on the sink for the convenience of the adults who take them; but these items, if swallowed in sufficient amounts by a child, can kill, or at the very least, make the child desperately ill."

"Don't cajole children into taking medicine by calling it candy," warns Dr. Meyers. "For instance, bright red and green M&M candies look like iron tablets, and the child may already be used to being given candy-flavored aspirins when he is ill and may expect that any tablet he sees is candy. Calling medications candy is courting disaster."

"Keeping aspirin on a high shelf and taking bleaches out of the kitchen sink cabinet would alone reduce the incidence of poisonings significantly," Dr. Meyers continues.

Poisons in the Bathroom

The average medicine cabinet contains many pitfalls for the curious child who is capable of climbing to reach it: sleeping pills, tranquilizers, birth control pills, reducing pills, etc., all potential killers if too many are consumed. Other dangerous items are home permanents, nail polishes, lighter fluid, and hair dyes. "All medications should be stored in a high or locked cabinet," Dr. Meyers cautions.

Poisons in the Garage and Laundry Room

Garages and laundry rooms should be searched for harmful insecticides, snail bait, paint thinners, drain cleaners, soaps, detergents and bleaches. Nothing that contains even a trace of a poisonous substance

should be left where it is accessible to children. Dr. Meyers says that one should *never* store such things as paint thinners and insecticides in soft drink bottles or other food containers, but that they should *always* be kept in carefully labeled, closed containers. Also, when the label warns against the fumes of a product—insecticides, spray paints or cleaners . . . they should *never* be used indoors. Even cross-ventilation may not provide an adequate draft to remove the harmful fumes. Also, *all labels should be read carefully before using.*

Dr. Meyers gives a list of simple rules which will prevent poisoning:

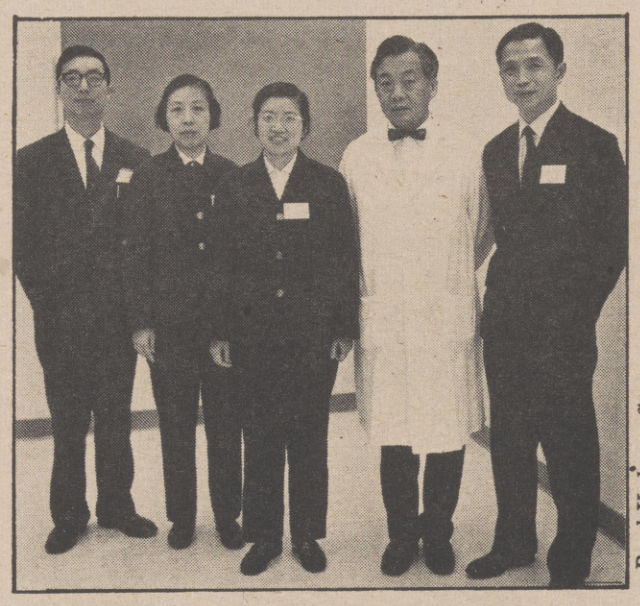
RULES FOR PREVENTING POISONING

1. Store medicines in a high or locked cabinet; those used regularly—aspirin, sedatives, iron, contraceptive pills—should not be kept in an easily accessible handbag or on a table or low shelf. *Keep away from children.*
2. Do not save unused prescription medications. If you do, they should be labeled with the name of the drug. *Store with care and keep away from children.*
3. Do not tell children that medicine is candy.
4. Do not store harmful chemicals in the same cabinet as foodstuffs. *Keep away from children.*
5. Label carefully all stored materials so that poisons will not be taken accidentally and so that the harmful substance can be identified to the doctor if it is taken accidentally.
6. Do not store poisons and harmful chemicals in cups, soft drink bottles or other food containers. Also, do not bring them home from work in such containers.
7. Check on what dangerous materials might be in the kitchen, bathroom, bedroom, garage, or laundry, and *store with care and keep away from children.*
8. Vent all gas heaters and stoves.
9. Write down and keep handy the phone numbers of your doctor and the nearest emergency hospital.

Dr. Meyers suggests keeping handy a small bottle of Syrup of Ipecac, obtainable from the druggist without a prescription; this is an excellent substance to induce vomiting, which the doctor may instruct you to use.

Joan Spiegelhalter

Visiting Scientists



Paul Kolsanoff

Scientists from the People's Republic of China recently visited the UCSF campus. They were the third of four delegations that will visit the United States this year as a result of exchange agreements reached in China last May. The visits are sponsored by the American Council of Learned Societies, the National Academy of Sciences, and the Social Science Research Council. Their Committee on Scholarly Communication hosts the groups and works with the Chinese Scientific and Technical Association under the mutual agreement.

The delegation included Ms. Ku Yun-hui, Vice-Chairman, Department of Physiology at Peking Medical College and Mr. Chang Tsai, a member of the Ministry of Foreign Affairs; and three members of the Chinese Academy of Medical Sciences, Ms. Lou Ai-lin, Vice-Chairman, Department of Physiology, Mr. Niu Shih-ju, Director of the Public Health Research Section of the Institute of Public Health, and Mr. Chou Lung-wu, applied research worker.

Members of the scholarly delegation that visited UCSF are concerned with the physiology of pain and during the two days spent in San Francisco they met with physiologists and pharmacologists.

Mrs. Margaret Tan, Associate Specialist in Biochemistry, acted as interpreter for the group, although most members spoke English. Chancellor Francis A. Sooy, M.D., hosted a luncheon at University House attended by the delegates and Deans Marjorie S. Dunlap, Jere E. Goyan, Harold A. Harper, Julius R. Krevans, Ben W. Pavone; Drs. Leslie L. Bennett, Ephraim P. Engleman, Seymour M. Farber, Howard L. Fields, William F. Ganong, Yoshio Hosobuchi, William K. Hamilton, Philip R. Lee, C. H. Li, Henry D. Moon, Eric Owyang, Abraham M. Rudolph, J. B. de C. M. Saunders, Ilza Veith, E. Leong Way; Mrs. Margaret Tan, and Shing-shen Chern.

Other institutions to be visited by the scientists include Massachusetts Institute of Technology; the National Library of Medicine in Washington, D.C.; Johns Hopkins University in Baltimore; Harvard University, Massachusetts General Hospital; Columbia College of Physicians and Surgeons; the Mayo Clinic in Rochester, Minnesota; and many other medical centers and scientific institutions across the United States.

Emergency

WHAT TO DO
IN CASE OF ACCIDENTAL POISONING

1. Phone your nearest Emergency Hospital (keep the number near the phone) and your doctor. *The important thing is to get the victim to medical aid as soon as possible.*
2. Keep calm and act efficiently so as to save time.
3. If possible, save a sample of the poison and its container to show the doctor.
4. If a caustic material (burning) material gets in the eyes or on the skin, flush thoroughly with water immediately. Be sure and hold the lids open when washing the eyes.

Book Notes

Dr. Marcella Z. Davis is the author of a recently published book entitled *Living With Multiple Sclerosis*. It is a concise statement about the disease and its management. Although written particularly for health workers the book's contents offer insight to anyone who must cope with individuals suffering from this disease.

Multiple sclerosis and other closely related disorders of the nervous system afflicts an estimated 500,000 persons in the United States. A chronic disease that leads to progressively impaired bodily function, its cause continues to baffle researchers. Normally, nerve fibers are covered with a sheath of fatty substance called myelin. The formation of patches of thickened tissues, called plaques, on the sheath leads to destruction of nerve fibers. This destruction is permanent and causes disruption of messages sent to the brain that control motor and sensory impulses. Symptoms vary according to the location of nerve fibers attacked by plaque.

In her book, Dr. Davis, a Clinical Professor of Nursing at UCSF, views the problems associated with multiple sclerosis as they relate to personal and social needs of the patient. Her study reflects the view that an individual's state of health cannot be isolated from his daily living situation.

A member of the School of Nursing faculty at UCSF, Dr. Davis also taught at the Royal College of Nursing in Edinburgh, Scotland, while a Fullbright scholar and worked on her own research at the Belmont Hospital Rehabilitation Unit in Great Britain.

Dr. Davis is currently completing work in collaboration with her colleagues on the care and management of pain in hospitalized patients.

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Davis, Marcella Zaleski, R.N., D.N.S. *Living With Multiple Sclerosis,* 80 pp, Charles C. Thomas Publisher, Springfield, Illinois 1973.

Memo



I am pleased to report that our Physical Plant Department has taken the lead in developing a responsive program for energy conservation on campus.

Mr. Nat Garibaldi's memos to the Campus Community regarding the "energy Crunch" set forth the many actions that have been taken, will be taken in the near future, or are under consideration. The following are some of the measures recommended by Mr. Garibaldi of which we should all be especially aware:

Whenever possible turn off equipment not in use.
Turn off lights in rooms at the end of the day.
Report malfunctioning equipment immediately.
Report leaky toilets or faucets (especially hot water) immediately.
Reset thermostats to 69 or 70 degrees.

No measures involving light or heat reduction will be taken that might be detrimental to health, safety, patient care, or security. Please let the Physical Plant Department know immediately if you think there may be potentially hazardous conditions related to any of the conservation activities.

In addition, it would be appreciated if members of the campus voluntarily observe a 55-mile-per-hour speed limit on freeways when driving University vehicles.

I urge all members of the campus community to cooperate in these efforts, and I know we will achieve significant results.

Out With the Old, In With the New

The "Old" was the student residence at 610 Parnassus Avenue. The seven story structure on the corner of 3rd and Parnassus Avenues was demolished recently because a seismic study indicated a high probability that extensive damage would occur in the event of an earthquake.

The "New" is the opening up of another magnificent view of the Golden Gate Headlands and the Pacific Ocean. The "New" will also be the development of an attractive mini park and Child Care Center on the site. The proposed Child Care Center will be a low-rise structure taking advantage of the sloping site so that it will not obstruct the new view and the welcome feeling of openness.

Preliminary landscaping of the mini park will begin immediately. Construction of the Child Care Center is dependent upon obtaining funding.

Francis A. Sooy, M.D. Chancellor



Currently on exhibition at the M. H. de Young Museum are 100 pieces of pottery from the Southwest. The "Contemporary Native American Ceramics" exhibit will remain through February 15, 1974.

At the Museums

The Renaissance print collections will continue to be shown at the California Palace of the Legion of Honor through January 13th. A unique introduction to the collection is presented at 12:30 daily in an anteroom adjacent to the galleries occupied by the "Prints of the Italian Renaissance." The introduction includes slides of some of the prints, as well as a description of the methods of Renaissance printmaking and a display of printmaker's tools.

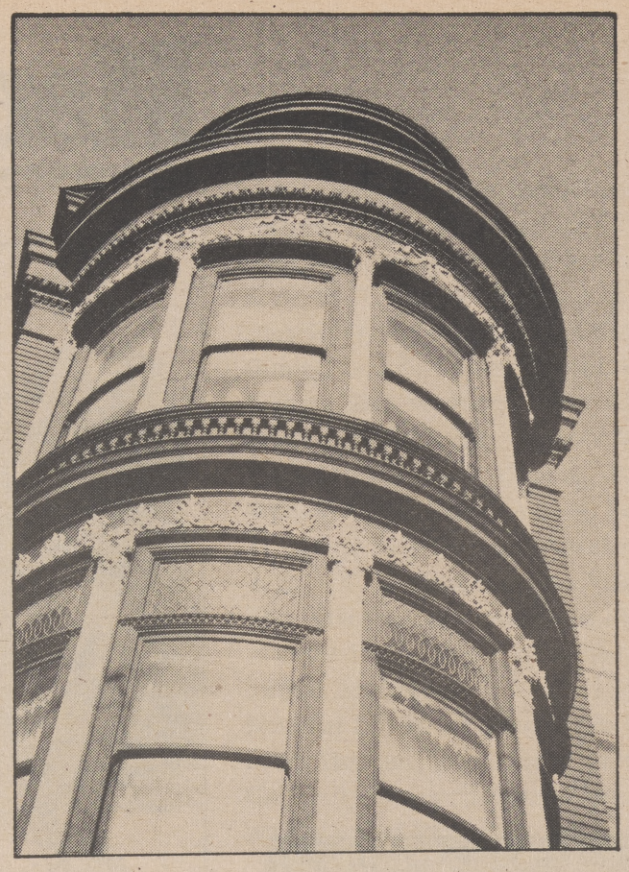
At the deYoung museum an exhibition by crafts award winners at the 1972 San Francisco Art Festival is on view through January 20th. Three categories are included in the exhibition: ceramics, jewelry, and textiles. Artists exhibiting are: Karen Clausen and Susan Hollenbeck, Florence Resnikoff, Donna Seid, Linda Charles, and Martha Roediger.



Tom Walters

The wrecking ball rests on a small heap of rubble, all that remains of the former Nurses Residence on Parnassus. A "mini" park will insure the panoramic view of the Golden Gate that is now visible. Formerly the seven-story building blocked the Gate and the hills of Marin from sight.

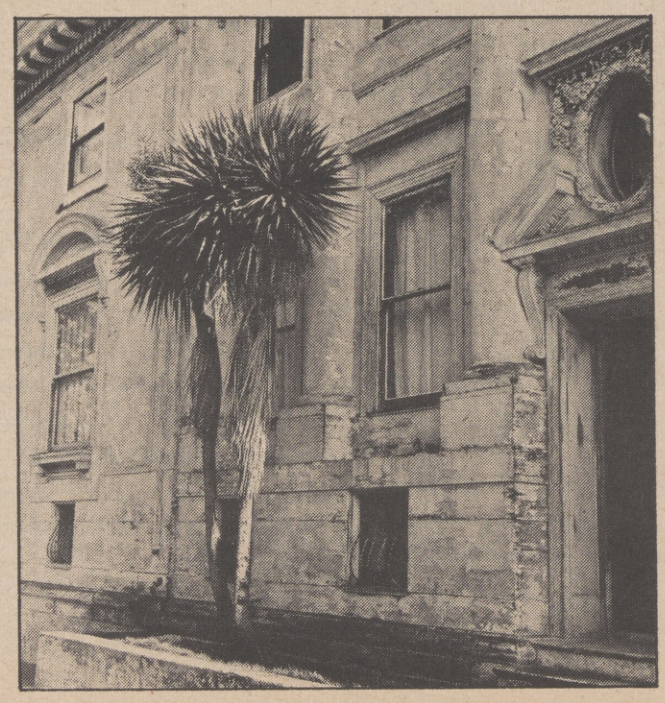






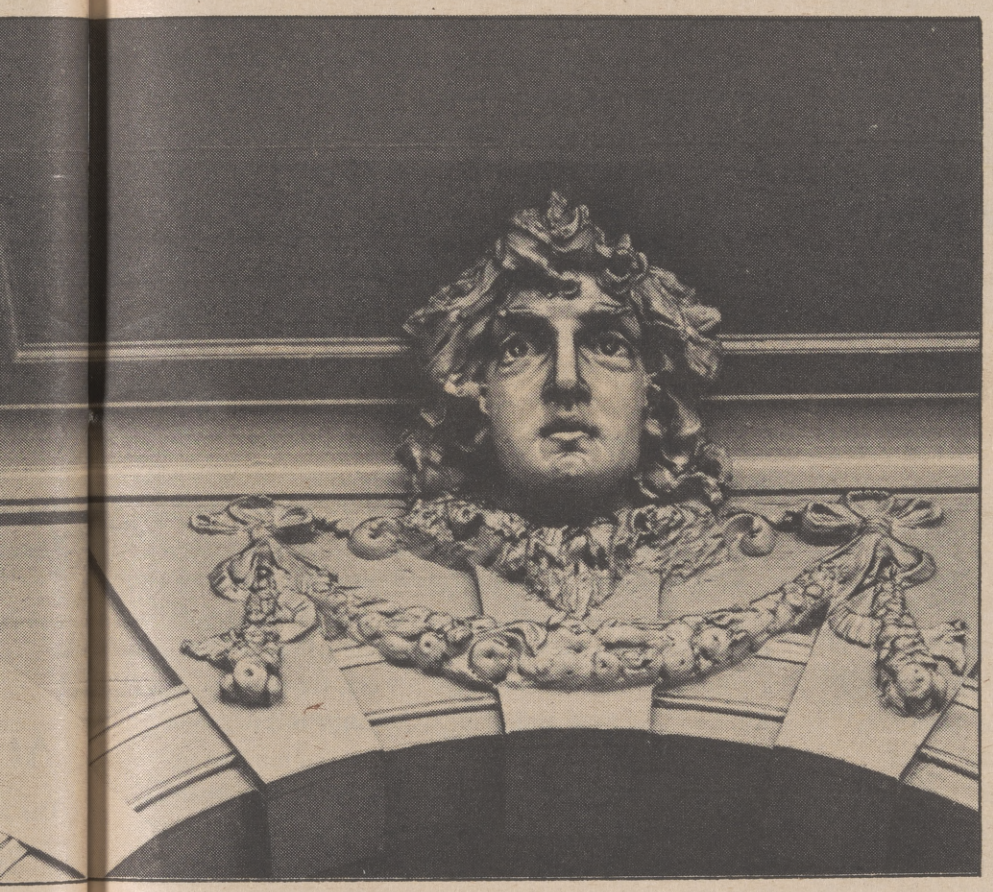










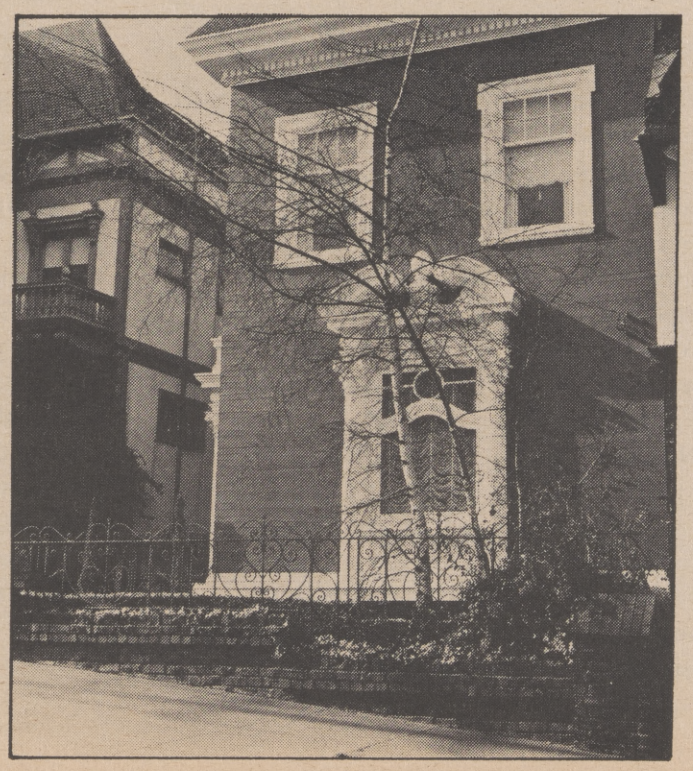


Among the goals of the Haight-Ashbury Improvement Association is the preservation and rehabilitation of buildings. Once one of the City's most charming residential areas, Haight-Ashbury has a cross-section of Victorian, carpenter's Gothic, mediterranean, early California, and many other styles of architecture. Buildings such as these in the Haight-Ashbury give San Francisco its unique visual texture.

Merchants and property owners in the Haight-Ashbury have launched a membership drive for their newly reorganized Improvement Association and response is excellent. Formerly named the Haight-Ashbury Merchants and Improvement Association, the organization dates from 1906, when Haight Street was a popular shopping area for those going to Golden Gate Park.

Persons interested in joining the Association should call Mrs. Anna Guth at 681-7749.

Photographs taken by David Johnson, Analyst in the Personnel Office.





On Campus

Dr. Fishman Given Royer Award

The Dr. J. Elliot Royer Award has been given this year to Robert A. Fishman, M.D., Professor and Chairman of the Department of Neurology, University of California, San Francisco. Established under the terms of the will of the late Dr. Royer, this annual honor is given to a Bay Area physician in recognition of significant contributions to the advancement of psychiatry or neurology.

Presentation of the award and a check in the amount of $15,000 was made by Julius R. Krevans, M.D., Dean of the School of Medicine and Chairman of the Royer Committee, in behalf of the Regents of the University of California at a special luncheon in Dr. Fishman's honor.

Dr. Fishman has contributed significantly to the continued education of physicians in Northern California through a series of neurology topics presented on closed circuit television to hospitals in northern California. His leadership in neurology has led to his recognition as one of the most eminent neurologists in the country. Dr. Fishman's work on metabolic disorders of the brain have provided important new insights into the treatment of diseases of the nervous system.

A member of the UCSF faculty since 1966 when he came to assume the chairmanship of the neurology department, Dr. Fishman previously was on the faculty of the Neurological Institute, Columbia-Presbyterian Medical Center in New York. He received his undergraduate degree in 1944 from Columbia University, and his M.D. degree from the University of Pennsylvania in 1947. He served his residency at Massachusetts General Hospital.

Dr. Fishman is a resident of Tiburon, California, where he lives with his wife, Peggy, and three daughters, Elizabeth, Alice, and Mary.

From Classroom To The Community

The distance in miles, and the difference in cultures is enormous between Swatow, in the southern part of China, and San Francisco. Lincoln Lim has bridged both. His English, learned from American missionaries in Thailand, is good. He translates into Cantonese and Mandarin for residents of Chinatown who neither speak nor understand English. He teaches youngsters at the Northeast Mental Health Service and visits older Chinese men and women who are isolated by language and custom from the society in which they live. He takes them to the doctor's office and he instructs them about nutrition and other health facts.

About a year ago, UCSF's Continuing Education in the Health Sciences started a series of classes and laboratory work to provide bilingual health workers for the community. This pilot project started with students who spoke English and Chinese or Tagalog. The goal of this program was to improve levels of general health through the counseling-education



Tom Walters

Lincoln Lim completed the bilingual health assistants program under the direction of UCSF's Continuing Education in the Health Sciences. While completing his classes, Mr. Lim started to work at Northeast Mental Health Service.

services of these assistants. In addition to nutrition subjects, the students were instructed by physiotherapists, rehabilitation specialists, and other health professionals in basic health support skills.

Mr. Lim had been a student of Social Welfare at the College of Education in Hong Kong. He had also been a youth worker in Bangkok with the American Baptist Mission. His skills and knowledge fitted perfectly into the UCSF training program.

Lincoln Lim is one of eighteen men and women who completed the bilingual health assistant program which was funded by a grant from the Office of Education, Division of Manpower and Development Training (HEW). Generous support was also given by the San Francisco Health Professions Council, which provided the stipends for the students and underwrote a portion of the program costs.

Lincoln Lim speaks with enthusiasm about the Neighborhood Nutrition and Health Worker program. "The director did a great deal of planning and organization to develop this program," he said.

"It helped me . . . gave me confidence," he noted. "The program increased my skills, and the living allowance made it possible for me, a new immigrant, to study and still support my family."

The Neighborhood Nutrition and Health Worker training program was developed by UCSF in collaboration with representatives from the Chinese-North Beach community. Health professionals from the Chinese-American community and representatives of public and private health agencies cooperated with the classroom, workshop, and field activities.

Cancer Research Applications

The President's Universitywide Cancer Research Coordinating Committee (Dr. K. B. DeOme, Executive Secretary) announces that applications for University of California cancer funds for 1974-75 are due by February 1, 1974.

Members of the academic senate, including emeriti, and appointees at 50 percent or more of full-time in the Adjunct Professor series, the Clinical Professor series, and the Professional Research series are eligible to apply.

The Committee wishes to encourage research projects involving human cancer. It is the intent of the Committee to support such projects in every way possible including support for more than one year (but excluding the costs of patient care) and assistance in obtaining extramural support.

Information and application forms are available from Virgil F. Finster, Business Officer, Cancer Research Coordinating Committee, 230 Warren Hall, Berkeley campus (phone ext. 2-4711).

Classes For VITA

An instruction class for employees interested in helping others prepare income tax returns will begin January 8, 1974. Persons completing the course will be eligible to join the Volunteer Income Tax Assistance program. Approximately 40 hours of instruction will be given by members of the Internal Revenue Service. Classes will be held on campus.

This past year VITA gave assistance to more than 200 employees at UCSF. The program will begin next year on March 12. Help will be available from VITA, a volunteer service, two days a week through April 11 . . . time and place to be announced. later.

Anyone interested in joining the instruction course should call Bill Edmonds, Assistant Training Coordinator in the Personnel Office. Extension 4278. Enrollment is now open.

Retirement Service Credit

Did you know that you can establish service credit in the University of California Retirement System (UCRS) for a leave of absence or sabbatical leave? You can also restore service credit for a period of previous employment at the University. The only requirement is that you must now be an active member of UCRS and have been a member at the time of your leave or previous employment.

To establish service credit for a leave of absence taken before July 1, 1966, you'll need to pay the missing contributions by July 1, 1974. If you took a leave between 1966 and 1971, you received service credit without contributing, but there will be a slight reduction in your retirement pension based on the contributions not made. You can compensate for this

reduction by contributing to one of the UCRS voluntary programs (by payroll deduction only). For leaves taken since 1971, the payment deadline is three years from the time you returned to the University.

To restore service credit for University employment terminated before July 1, 1971, you have three years from your date of rehire or until July 1, 1974, whichever is later, to repay contributions you withdrew when you left. If you terminated a University job since 1971, you have three years from the time you were rehired to pay back your contributions.

How Much Do You Pay?

In the case of a leave of absence without pay, you pay your regular retirement contribution and the University's regular contribution, plus interest on these contributions from the time you left until you finish payment.

In the case of a sabbatical leave, you get partial service credit in proportion to the percentage of salary you received during your sabbatical. If you received two-thirds of your salary, you must pay your contribution and the University's contribution on the remaining one-third to establish full service credit. You must also pay interest if payments are made after the usual contribution date.

For a military leave without pay taken before July 1, 1966, service credit is established when you pay your regular contribution plus interest. (You don't have to pay the University's contribution.) If you took a military leave after July 1, 1971, you received full service credit at no cost to you.

If you were previously employed by the University and withdrew your retirement funds when you left, you pay the amount of money you withdrew, plus interest from the time you withdrew it until it's paid back. If you were a noncontributing member of UCRS during your past employment, you will have to pay all contributions you would have normally made, plus interest.

Where Do You Get Payment Information?

To find out how much you need to pay to restore service credit in UCRS, write: University of California Retirement System, 192 University Hall, Berkeley, CA 94720. Attention Felix Dunnett. Your payments can be made by payroll deduction, personal check, or both. (The decision to make payments is irrevocable except in the voluntary programs.)

If you're a member of the Public Employees' Retirement System (PERS), you have until your retirement date to complete service credit payments for a leave of absence or period of previous employment. For more information on PERS, call the benefits counselor in your local personnel office.

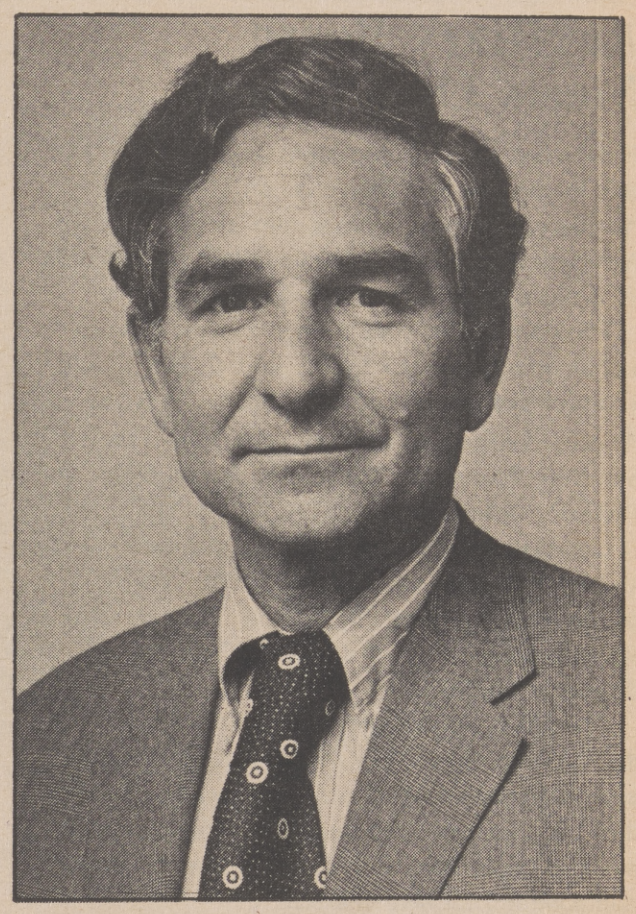
Your W-2 Form

Annual Withholding Tax Statements, Form W-2, will be mailed to Medical Center employees by January 31, 1974. These statements will cover all payments made during the calendar year 1973. They will include December 1972 earnings paid in January 1973: They will not include December 1973 earnings paid in January 1974.

To receive W-2 forms promptly, it is necessary that the name and address is correct and that a Social Security number has been issued. Any employee who does not have a Social Security number should submit a completed form SS-5; to record a change of address, submit a Form 1611 to the Accounting Office. Forms are available in every department.

Personnel Note

Don't forget the "Brown Bag Lunch" meetings with members of the Personnel Office. These informal sessions are held every Thursday from 12:00 noon to 1:00 p.m. in Room 617, School of Nursing. Topics discussed are determined by those who attend, and have included insurance, range adjustments and questions about policy relating to sick leave or vacation. Everyone is welcome and urged to attend.



Tom Walters

Robert A. Derzon, Director of Hospitals and Clinics at UCSF.

Faculty Wives' Notes

Don Mozley, KCBS Automotive Editor will be guest speaker at the UCSF Faculty Wives meeting on January 8, 1974. The meeting will be held at University House, 66 Johnstone Drive, San Francisco. All members are urged to attend. For transportation, directions, or additional information please call 681-0475.

☆ ☆ ☆

On February 6, 1974 at 11:00 a.m. the UCSF Faculty Wives will have their annual Silent Auction and luncheon for members and their guests. The event will be held in University House, 66 Johnstone Drive, San Francisco. Money from the Silent Auction goes to the Faculty Wives Fund for special projects, among which is the Foreign Scholars Loan Closet from which foreign scholars may borrow household items during their enrollment at UCSF.

The Faculty Wives welcome items to be auctioned —donations of unreturnable Christmas gifts, white elephants, baked goods, plants, antiques or objects d'art will be greatly appreciated. Donations can be brought to the January general meeting or to the Silent Auction, or given to the following members:

PENINSULA:	Marilyn Carman 300 Robinhood, Hillsborough
MARIN:	Margo Derzon 6 Dawn Place, Mill Valley
SAN FRANCISCO:	Beth Martinez 178 Amber Drive, San Francisco

For further information, please call Margo Derzon, chairperson, at 383-0766.

Derzon Elected

Robert A. Derzon, Director of Hospitals and Clinics was elected Chairman of the Council of Teaching Hospitals (COTH), a national organization that is one of three councils of the Association of American Medical Colleges (AAMC).

Teaching hospitals deliver over 25 percent of patient care given in this country. Over 400 hospitals belong to the AAMC which is also the official voice that speaks for these teaching hospitals, as well as for 109 medical schools and 50 academic societies. The hospitals whose interests are represented by AAMC are either owned by universities or have teaching affiliation with medical schools.

Mr. Derzon has been Director of Hospitals and Clinics at UCSF since April, 1970. Previously he was First Deputy Commissioner of Hospitals in New York City where he played a key role in the establishment of a public corporation to manage New York City's municipal hospital system.

Other health centers where Mr. Derzon held positions include New York University Medical Center, where he was Associate Director of the University Hospital and Special Assistant to the Director of NYU Medical Center; the University of Minnesota; and Rhode Island Hospital, in Providence.

A native of Milwaukee, Wisconsin, Mr. Derzon is a graduate of Amos Tuck School of Business Administration, Dartmouth College.

Auxiliary

Auxiliary Board Meets On Campus

For the first time, an on-campus dinner meeting was held by the Board of Directors of UC Hospitals Auxiliary. Members, spouses, and friends of the Auxiliary attended the festive mid-November event in the Golden Gate Room of Moffitt Hospital.

The program included a brief business meeting and an informative talk by Dr. John C. Hutchinson, a cardiologist. He spoke on the topic . . . "Heart Attacks: Understanding Them; Avoiding Them; Surviving Them." Dr. Hutchinson is Associate Professor of Medicine at UCSF.

Guests toured the Emergency and Admitting Areas and the three solariums which have been redecorated by the Auxiliary for use by patients. They also had an opportunity to view the Auxiliary's current art display in Moffitt lobby.

The cost of the delicious steak dinner, prepared by the Nutrition and Dietary department, was entirely covered by the members and guests, who paid for their own dinners. Even the flower arrangements on the tables were donated from the garden of Dietary staff member, Carolyn O'Brien.

Mrs. Ralph Audy, Auxiliary President, who planned the dinner meeting, was delighted with the turnout of 50, including a large number of men. She said she hopes there will be future opportunities for similar dinner meetings on campus.

Meditation Room

UC Hospitals Auxiliary members Mrs. Frank Fries and Mrs. Florence Witter are among the first contributors to the fund for a Meditation Room where family members and friends of patients may seek quiet and solitude. Working toward a goal of $5,000, Auxiliary President Kay Audy expressed gratitude for the response to the project.

In moments of crisis or grief, and during less critical periods the need for a peaceful place in which to meditate or pray or just sit quietly has long been apparent at UCSF. The effort by UC Hospitals Auxiliary to provide such an accommodation near the patient areas has the enthusiastic support of administration members, physicians, and staff nurses.

Anyone wishing to donate to the Meditation Room fund, or who wants additional information about it, may call Mrs. Kay Audy at 664-4137.

Holiday Decorations

This holiday season the UC Hospitals administration provided the Christmas trees that are in the patient areas and lobbies.

It was decided to replace the traditional live spruce and firs with artificial trees.

Decorating was a cooperative project: the UC Hospitals Auxiliary provided the ornaments and members of the Doctor's Wives hung the glittering baubles.



Paul Kolsanoff

A house that can be eaten! This sugary piece of architecture was made by volunteer Chris Holt for the pediatric unit in Moffitt Hospital.



Tom Walters

At the end of a successful day, the Gift Boutique was a complete sell-out. Weary Auxiliary members bagged the last few items for still eager customers.

Art Boutique

The Christmas Art Boutique arranged by Mrs. Barbara McCormick features the works of local artists. Paintings, scrolls, linoleum and wood block prints, and Currier and Ives prints are all available at prices that range from five to fifty dollars.

Among the art works exhibited are the paintings of children by Marilyn O'Hare; watercolors by Monique Plassman; batiks by Bill Gregg; block prints by Felicity Pruden, Fred Reisinger, and Pat Wipf; serigraphs by Lars Hawkes; and oil paintings by Ray Guerrero.

The works of art will remain in the Moffitt Hospital Lobby through December 31. Orders for any of the art works may be placed at the Volunteer's Office, Room 114 Moffitt.

The Christmas Art Boutique is an annual event arranged by the Auxiliary. It is one of their activities to raise funds for equipment and personal items that add to patient-care services.



Block print by Pat Wipf. The original, entitled "Geranium" is in red on white paper.

Auxiliary Membership Application
Fill this out and mail to: UC Hospitals Auxiliary, Moffitt Hospital, UC San Francisco, San Francisco 94143.
NAME _____
ADDRESS _____
_____

Type of membership: Active—$10 per year; Alumni—$10 per year; Volunteer (those active in volunteer service in UC Hospitals)—$2 per year; Student—open to all students and their spouses—$2 a year; Contributing—$25 per year; Sustaining—$50 a year; Patron—$100 a year; Sponsor—$150 or more per year; Life—$500. Membership is tax deductible.

SFGH

New Attack On Child Abuse

For the first time, a comprehensive citywide effort is underway in San Francisco to help the battered child and prevent the tragedy of child abuse among all segments of the community.

The program, which involves agencies, organizations and hospitals concerned with the problem, is funded under a $72,000 grant from the Rosenberg Foundation to Dr. Moses Grossman, UCSF Professor of Pediatrics and Chief of the Pediatrics Service at San Francisco General Hospital.

It began in November with the creation of a San Francisco Council on Child Abuse, with its own centrally located office and a full-time staff. Miss Michael Schwartz, for the past five years a Juvenile Probation Officer in San Francisco, has been employed as Coordinator.

Dr. Grossman described the new Council as "an action program." He pointed out that the project is an outgrowth of long-time informal coordinating efforts among local agencies such as the Police, Juvenile Court, Protective Services, and SFGH Pediatrics Service. Examples of other services and individuals which have been concerned with the problem are Pediatric services at Letterman, St. Luke's, Kaiser Hospitals and the UCSF Medical Center, probation officers at the Youth Guidance Center, and many individual pediatricians.

Some research on the battered child has been carried on at San Francisco General Hospital, consisting of retrospective review and long-term follow-up of battered children and their families. Recently, the Child and Family Project, a day-care and treatment program under the direction of Elsa Ten Broeck, sponsored by the Mission Child Care Consortium, Inc., was organized under a grant from the Department of Health, Education and Welfare. This is an important new dimension in helping battered children and their families.

The problem of child abuse exists in all societies and has been documented since ancient times. However, in 1946, through the work of Dr. J. Caffey, a radiologist, an unusual medical syndrome in children was discovered. It related injuries of the long bones to injuries of the head. The causes of these injuries were not clear until 1955, when other researchers suggested they were the result of willful trauma perpetrated against the child by an adult.

More and more, pediatricians were able to identify victims of deliberate abuse by the nature of the fractures incurred and the fact that such injuries tended to occur repeatedly among the same children. In 1961, at a seminar on child abuse, Dr. C. Henry Kempe, Chief of Pediatrics at the University of Colorado Medical Center, coined the term "battered child."

The problem has stimulated many studies on the dynamics of abusive families, but preventive and treatment programs have been slower to develop. Reporting by physicians, nurses, and others who come into contact with battered children is required by law in all states; however, such reporting is incomplete, particularly among privately practicing physicians. Most cases brought to the attention of appropriate agencies involve the poor who are treated in tax-supported hospitals and clinics.

Michael Schwartz said, in an interview, that the new project's first priority is to bring together representatives of every agency and professional group involved in any way with the child abuse problem. From this broadly based representation, the complete Coordinating Council will be formed.

"Then, after existing services have been identified and evaluated, the Council will be able to assist in developing special services, many of which have been successfully offered in other areas.

Such services include the "Crisis Hotline" telephone service, protective nurseries, lay therapists, and "parents ananymous" groups.

Of prime importance, according to Dr. Grossman and Miss Schwartz, is the need for an educational program that will include the professional level and also reach potentially abusive parents.

Studies have shed light on many of the forces which can cause child abuse and have demonstrated that "battering parents often feel isolated and unique in their problems with their children," added Dr. Grossman.

"All parents, from time to time, experience negative feelings toward their children and should recognize that it is necessary to find healthy ways to express these feelings. Child abuse will continue until society recognizes that the task of child rearing without some assistance is beyond the ability of many parents."

"Parents need concrete information and advice on how to cope with personal frustrations related to child rearing. They need an opportunity to discuss these problems in a supportive atmosphere where they are neither condemned nor punished."

Claire Wray



Tom Walters

Dr. Moses Grossman, Professor of Pediatrics, who heads the Battered Child program established recently with funding from the Rosenberg Foundation.



Tom Walters

Michael Schwartz, Coordinator of the San Francisco Council on Child Abuse.

New Recognition Program

A special reserved parking space at the hospital's main entrance is one of the prizes being awarded to the "Housekeeping Department Employee of the Month" in a new "recognition program" at SFGH. The winner has exclusive use of the parking space throughout the month, or the privilege may be given to a fellow-employee, if the winner doesn't drive to work.

Other prizes are a $25 United States Savings Bond, and a "Certificate of Achievement." Candidates for the award are nominated by ballots submitted by fellow employees, nurses, medical staff, and patients. Nomination is based on outstanding performance, initiative, attitude and cooperation, and attendance.

Dr. F. William Blaisdell, UCSF Professor of Surgery and Chief of Surgery at SFGH, was instrumental in establishing the award. He says: "Hospital cleanliness is essential for many reasons, among them preventing complications in surgery. No service performed in the hospital is more important to patient care."

Hospitals and Clinics:



Christopher Guerrero, age 6, is the "theme child" for the "Light Up a Face!" fund campaign of the Volunteer Auxiliary to SFGH. The campaign was initiated when, in recognition of the energy crisis, the Auxiliary cancelled plans to sponsor its traditional benefit . . . "Turning on of the Christmas Lights" . . . opening the holiday season in Ghirardelli Square. To help "light up a face" at our City-supported hospital . . . and turn on your own inner-glow for Christmas . . . send a tax-deductible donation to the Volunteer Auxiliary, San Francisco General Hospital, c/o P.O. Box 40567, San Francisco, CA 94140.

Weekly Trauma Conference

Every Thursday at 4:30 p.m. in the surgical amphitheater, the hospital's nationally acclaimed Trauma Center sponsors a multi-disciplinary discussion of trauma cases currently under treatment. All interested physicians are welcome to attend these conferences in which members of the neurosurgery, orthopedic surgery, anesthesia, and trauma service staff take part.

During the recent hospital staff blood drive, both volunteer blood donors as well as those employees and staff members who could not or would not give blood, had the advantage of a free blood typing service performed by the Irwin Memorial Blood Bank of the San Francisco Medical Society.

Special cards showing the blood type were sent to these individuals, and the hospital is keeping a master file of this information for possible use as part of its Disaster Program.

According to Dr. George F. Sheldon, UCSF Assistant Professor of Surgery and Chief, SFGH Trauma Service, the mobile unit of Irwin Blood Bank will continue to perform this blood typing service during its periodic visits to the hospital.

Year End Message

As 1973 concludes, the University of California Hospitals and Clinics, along with the other major teaching-patient care centers of the United States, faces an extraordinary array of major issues and opportunities.

Nearly two years of economic controls by the federal government have tended to limit our growth as well as our financial vitality. The economic controls of Phase IV which have been proposed at this writing will surely continue to press hard upon the nation's prestigious referral and teaching hospitals.

Further, the national trend to develop alternatives to expensive acute care services is being felt at our campus where ambulatory services grow as inpatient days decrease slightly. Although our in-hospital admissions have stayed almost constant, our length of stay per admission has shortened. The trend toward shorter hospitalization is the result of more effective utilization of resources and, in my view, is a tribute to more judicious choices of health care services by our faculty and house staff.

The combined impacts of fewer patient-days and additional ambulatory care have made the financing of a teaching hospital more precarious than ever before. Ambulatory care in an academic health science center tends to be more expensive than conventional office care and, in our particular case, must be heavily financed by state-supported clinical teaching funds.

With the multiplicity of financial pressures, all of our staff, both employees and physician faculty members, are showing remarkable adaptability to these forces of change. I am grateful to all of our personnel who, despite this overlay of intense external controls, are constantly determined to maintain and improve the quality of services to our patients. Clearly our human resources at U.C. are the most vital resources in the care of the ill and it is through these many individuals that our patients receive not only scientific, but humane health care.

As the year closes, I can look back over the countless letters of appreciative patients, the new and vigorous leadership in Nursing, the many and very generous contributions of time and money by our volunteers and our Auxiliary, the several improvements in our management of clinical teaching support and patients accounts receivable, the reconstruction and refurbishing—some of which is still underway—in such diverse areas as the laundry, Moffitt, radiology, patient rooms and solaria; and the exciting opportunities and hard work that has accompanied the opening of a new Ambulatory Care Center. These are a few of our many major accomplishments this year.

We continue to have strong support from our Deans on matters affecting the hospitals and clinics and a growing understanding of the Medical School faculty for the need to develop with us sound and effective clinical care programs so critical to the ultimate success of all of our activities on this campus.

On behalf of my staff and myself, I want to wish each of you and your families an especially joyous holiday season and a New Year of peace and contentment.

Robert A. Derzon, Director
Hospitals and Clinics

Holiday Staff

Although New Year's Eve (December 31) is a University holiday, it will be another working day for many of the staff of the hospitals' inpatient areas, the outpatient clinics, and such support services as surgery, x-ray, and clinical laboratories.

Similar high levels of staffing are provided on other University holidays, such as the day following Thanksgiving and the Spring holiday. An exception is the day after Christmas when somewhat more minimal staffing is provided to meet the year's lowest level of demands.

Additional holiday staffing is provided solely in the interest of service and convenience to patients, particularly outpatients. In fact, according to Hospital Administration, the cost of staffing at premium pay exceeds the income generated on holidays when activity is at its lightest.

A New Bill Of Rights

The role of the consumer is changing from one of passive recipient to active partner in health care. An important development in recognition of this trend is our new Patient Bill of Rights—and Responsibilities, compiled by representatives of the UC Hospitals and Clinics staffs.

For the past month, an educational program has been in progress to stimulate awareness and understanding of the Patient Bill of Rights among the staffs of all departments. Beginning January 1, copies of the Bill of Rights will be included in the informational packet provided at the bedsides of all patients hospitalized here at UCSF.

A basic Patient Bill of Rights was first issued by the American Hospital Association in 1972. It covers such points as the patient's right to full information regarding his diagnosis, prognosis, and course of treatment; the right to know by name, the physician responsible for coordinating one's care; the right to privacy; the right to participate actively in decisions regarding one's care and treatment; and others.

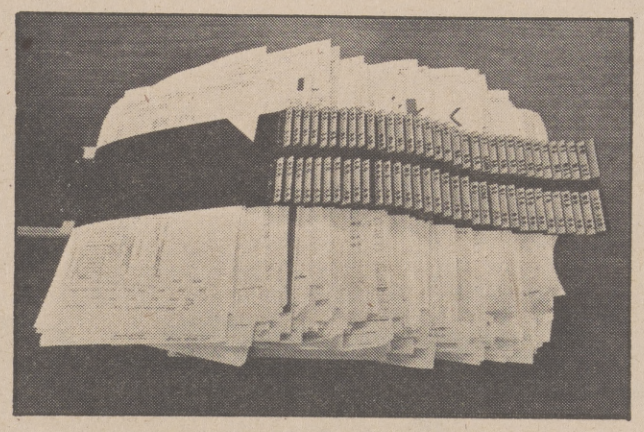
This basic statement is being adapted by many hospitals and medical centers to suit their individual needs and purposes. Before drafting our final version of the Patient Bill of Rights, plus an added section on Patient Responsibilities, the UC Hospitals and Clinics staff consulted directly with patients. A random sampling of 134 patients, including representation from various ethnic groups, participated in

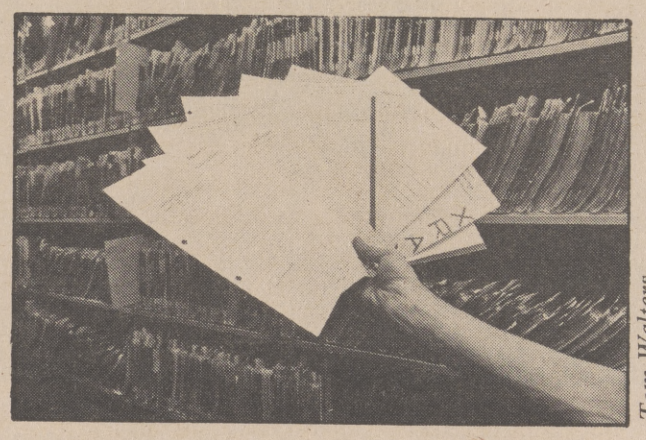
a survey conducted by the members of the Department of Social Work. These patients reviewed the proposed statement and expressed their reactions in answer to a questionnaire.

The overwhelming majority approved the idea of a Patient Bill of Rights; some expressed surprise that such rights existed; others suggested editorial changes —and a number of these recommendations were incorporated in the final statement.

Those who have been involved in developing the Patient Bill of Rights—and Responsibilities—agree that its effectiveness will depend on a continuing effort on the part of staff and patients to put the principles it embodies into practice.

Another new addition to the patient kit, is the newly revised booklet, "Your Hospital." This booklet given to all inpatients as an introduction to the hospital and its services, includes, for the first time, a large tear-out coupon for patient comments. The coupon is in the form of a pre-paid postcard addressed to the Director of Hospitals and Clinics. It invites constructive criticism as well as favorable comments and may be filled in by the patient during his hospital stay or mailed after he goes home. The patient may withhold his name if he prefers, but all signed cards will receive a personal reply from Robert A. Derzon, Director of Hospitals and Clinics.





Tom Walters

A handful of different forms that become part of a patient's record. Alphabetising, coding, computerizing . . . all are used to keep an accurate profile of each patient's history of health and care at UCSF.

Medical Records Are Part Of Health Care

Every day, seven days a week, 24 hours a day, a procession of medical records begins a long journey through the UCSF Medical Center. Let's travel along and see where they go, and what happens to them along the way.

Each record begins with either the patient's hospital admittance sheet or an outpatient registration form. This initial identification information may originate in the clinics, in the emergency room, or in the Admissions department, itself. It includes personal information about the patient, such as name, date of birth, address, as well as the name of the physician and medical service, diagnosis, anticipated length of hospitalization, insurance information, and many other pertinent items. Attached is the "Conditions of Admission"—or consent—form, signed by the patient (or parent or guardian).

All inpatient records flow initially through the Moffitt Hospital Admissions department. There, a call is made to the Patient Index file area in Medical Records to determine whether the patient is a new or repeat admission. If the patient is being admitted for the first time, a number is assigned to him. If he is being re-admitted, Admissions requests the previous record for use on the hospital floor and the patient retains the original number. A cherry colored sheet is inserted to separate the new hospital record from the others.

An addressograph plate is imprinted with the patient's name, number, and certain other information on the admittance sheet. This plate, and the admission forms will now follow the patient through the course of his hospitalization. From Admissions, they go to the floor where the patient is assigned. There they are kept in a metal folder, designed to hang in a special rack at the nursing station. The folder follows the patient when he leaves the floor for various procedures, such as physical therapy, x-ray, or other diagnostic procedures.

A sheaf of documents rapidly accumulates in the folder. The patient history, graphic charts recording vital signs, x-ray, lab reports, operative and anesthesia reports, nurses' notes, etc., are added in chronological order from bottom to top. Thus, the medical record becomes a minutely detailed report of every aspect of the patient's care, treatment, and progress involving the teamwork of those in many disciplines. Any individual specialty clinic has complete information about the patient as a whole person through the medical record.

When the patient is discharged, the record goes to the Medical Record department, where its first stop is at the Preliminary, or Audit desk. Medical records, arriving at a rate of some 1600 a month, are reviewed against a checklist to see if they are complete. If any document is absent, the record, now bound into its own manila folder, is held in the Active Record file, and the physician is contacted to complete it.

Conspicuously printed on the cover of the medical record folder are the words: "Confidential Medical Record—May Not Be Removed From This Campus." Beneath these headings, the medical record is defined as "a confidential medico-legal document, compiled for the benefit of the patient, doctor, and Medical Center," and following this are brief regulations designed to protect the medical record information which belongs, above all, to the patient.

Two edges of the manila folder are each banded with three strips of color. Nine different code colors are used to represent the digits 0 through 9, and new Medical Record personnel quickly learn to associate the colors on the edges of the folder with the last set of digits of the patient number. This color coding system is designed for easier filing and retrieval.

The record of the discharged patient is kept in the Active Record file until complete. These records may be needed for return clinic visits, current correspondence concerning the case, insurance billing, Social Service followup, and physician review in teaching and research. In almost all cases other than readmission and outpatient visits, the users are required to come to the Medical Record department to consult the records, which are not permitted to leave the department.

Because the records of patients recently discharged from the hospital are needed by so many different individuals at the same time, the Active Record file system was created to meet these needs and at the same time assure the availability of the records for patient visits. Restricting users of the records to the department makes the records more easily available for patient visits, a problem faced by many large medical centers.

Medical records are sometimes subject to subpoena, and such records are kept in a special file under supervision of staff specially trained in legal ramifications of medical records.

Completed records no longer needed in the Active Record file may go either to the Master file—ultimate destination of all inpatient and outpatient records—or to the Coding area for abstracting. Eventually, all inpatient records flow across the Coding desk where an abstract "patient profile" is recorded by means of pencil markings on a special computer form.

All kinds of information on patient characteristics and patient care are coded by number—including the patient's age, sex, height and weight, marital status, type of treatment, including operations, procedures and medications, length of stay, source of payment and hundreds of other items. The coded sheets containing this confidential information are sent in batches of 100 to the PAS (Professional Activity Study) computer center in Ann Arbor, Mich. There the data is further abstracted, filed, and crossfiled.

Computer printouts are returned regularly to the Medical Record department for filing. Specific data may be retrieved from the PAS data bank to obtain almost unlimited combinations of information useful in improving patient care or in furthering lifesaving medical research.

When a record has finally gone to the Master file and has remained inactive for five years, the medical record reaches the final destination in its long journey. The original record is removed from the file, microfilmed and destroyed, and a miniature copy is retained in the Microfilm file indefinitely.

Claire Wray

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Inside

UCSF physicians have pioneered in the development of diagnostic tests and treatment for newborn infants. The mortality rate for babies who have respiratory distress at birth has been cut in half. 1

The Winter Solstice in December marks the beginning of the sun's journey south and the return of more daylight hours. It is the focal point for many celebrations. The creation of the San Francisco Council on Child 4

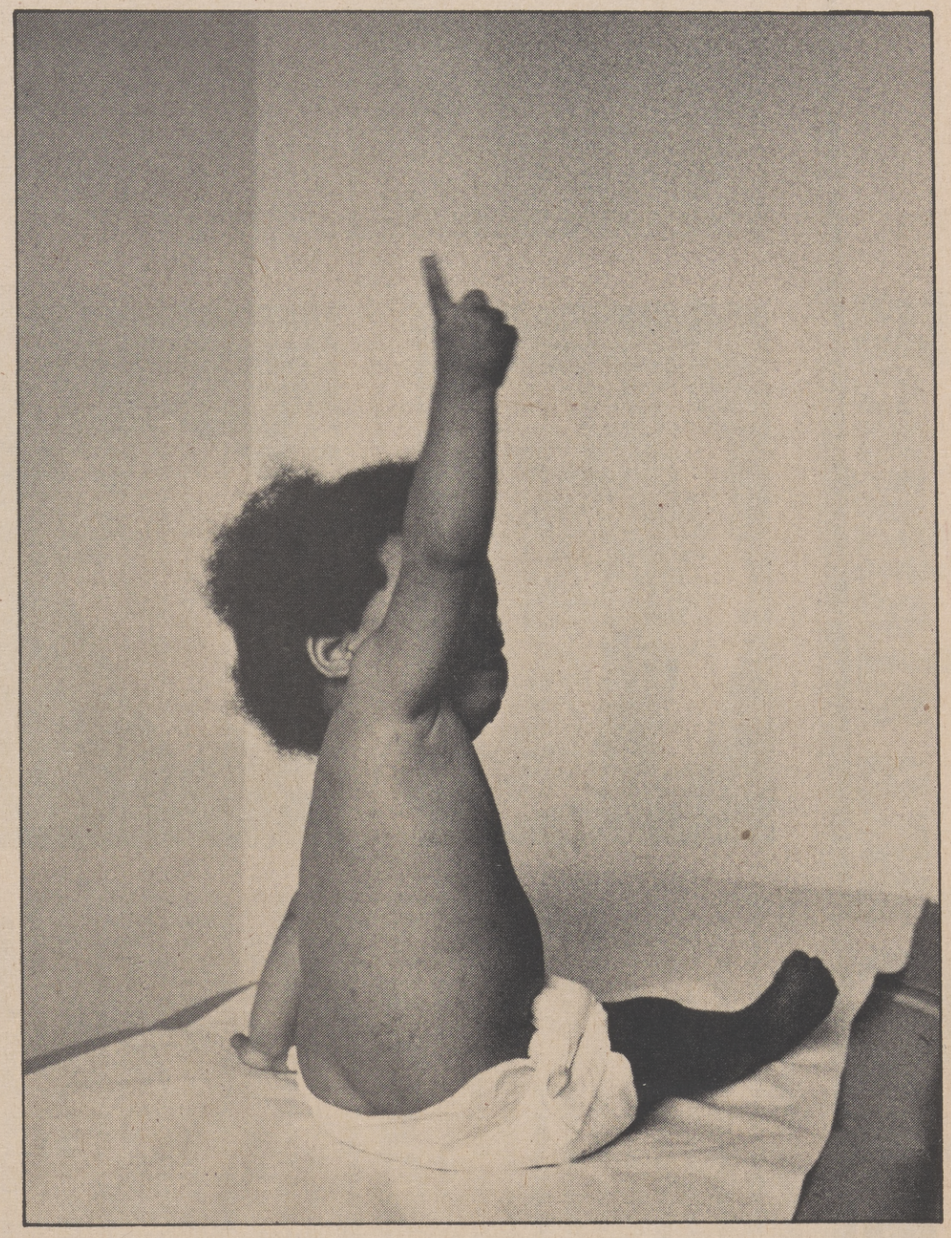
Check your cabinets, closets, and cupboards to remove household poisons from the reach of toddlers and young chlldren. Many cleaning agents are toxic and may be stored where youngsters have easy access to them. 5

Abuse is a new, city-wide effort to prevent the tragedy of battered children at all levels of society. A grant from the Rosenberg Foundation to Dr. Moses Grossman, UCSF Professor of Pediatrics gets the program underway. 13

A medical record is a multi-form messenger with complete health information to assure good care for patients in the UC Hospitals and Clinics. 15

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Behold! The Feast Of Lights (See page 4)

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